



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

**Requestor Name**

FOREST PARK MEDICAL CENTER

**Respondent Name**

EMPLOYERS INSURANCE CO OF WAUSAU

**MFDR Tracking Number**

M4-14-3212-01

**Carrier's Austin Representative Box**

Box Number 01

**MFDR Date Received**

JUNE 23, 2014

### **SUMMARY OF FINDINGS**

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2013 through May 16, 2013	Inpatient Hospital Services	\$74,268.70	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
  - U301 – This item has been reviewed on a previously submitted bill, or is currently in process. Notification of decision has been previously provided or will be issued upon completion of our review.
  - X045 – Please resubmit with a valid DRG code. For reconsideration please submit appeal with EOP and billing form with valid DRG Code.
  - X667 – The medical efficacy of this procedure has not been established.
  - Z652 – Recommendation of payment has been based on a procedure code which best describes services rendered.

**Issue**

- Did the requestor waive the right to medical fee dispute resolution?

**Findings**

- 28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are May 15, 2013 through May 16, 2013. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on June 23, 2014. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307, subparagraph (B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

## **Conclusion**

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

## ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

## **Authorized Signature**

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ October 23, 2014 Date
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_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ October 23, 2014 Date
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## ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**